

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34357**

Registration District No. **10 1943**

Primary Registration District No. **3008**

Registrar's No. **365**

1. PLACE OF DEATH:

(a) County **Callaway**  
(b) City or town **Fulton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **State Hospital No. 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 mo. 22 days**  
In this community **2 month 22 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Edward T Wright**

3. (b) If veteran, name war **OK** 3. (c) Social Security No. **no**

4. Sex **male** 5. Color or race **live white** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Flora Wright** 6. (c) Age of husband or wife if alive **OK** years  
7. Birth date of deceased **Sept 2, 1862**  
(Month) (Day) (Year)

8. AGE: Years **81** Months **1** Days **28** If less than one day hr. min.

9. Birthplace **Springfield** (City, town, or county) **Ill.** (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Richard Wright** 9  
13. Birthplace **OK** (City, town, or county) (State or foreign country)  
14. Maiden name **OK**  
15. Birthplace **OK** (City, town, or county) (State or foreign country)

16. (a) Informant **Flora Wright**  
(b) Address **Lebanon Mo**

17. (a) **Removal** (b) Date thereof **Nov 1, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Lebanon Mo**

18. (a) Signature of funeral director **Paul Wallace**  
(b) Address **Fulton Missouri**

19. (a) **11-1-1943** (b) **Josie Mosierhoff**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Saddle 14**  
(c) City or town **Lebanon** (If outside city or town limits, write "RURAL") **2**  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **30** year **1943** hour **1** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **Oct 1**, 19**43**, to **Oct 30**, 19**43**; that I last saw him alive on **Oct 30**, 19**43**; and that death occurred on the date and hour stated above.

Immediate cause of death **Polar Pneumonia**

Due to **General arterio sclerosis**

Due to

Other conditions (Include pregnancy within 3 months of death) **108**

Major findings: Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **James J. Jones** (M. D. or other)  
Address **Fulton Mo** Date signed **9/1/43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**